always will be considered as acting on behalf of health care providers if it makes a donation to the State. The amount of the organization's donation to the State, in a State fiscal year, that will be considered health care related, will be based on the percentage of donations the organization received from the providers during that period.

§ 433.53 State plan requirements.

A State plan must provide that—

(a) State (as distinguished from local) funds will be used both for medical assistance and administration;

(b) State funds will be used to pay at least 40 percent of the non-Federal share of total expenditures under the plan; and

(c) State and Federal funds will be apportioned among the political subdivisions of the State on a basis that assures that—

(1) Individuals in similar circumstances will be treated similarly throughout the State; and

(2) If there is local financial participation, lack of funds from local sources will not result in lowering the amount, duration, scope, or quality of services or level of administration under the plan in any part of the State.

[57 FR 55138, Nov. 24, 1992; 58 FR 6095, Jan. 26, 1993]

§ 433.54 Bona fide donations.

(a) A bona fide donation means a provider-related donation, as defined in § 433.52, made to the State or unit of local government, that has no direct or indirect relationship, as described in paragraph (b) of this section, to Medicaid payments made to—

(1) The health care provider;

(2) Any related entity providing health care items and services; or

(3) Other providers furnishing the same class of items or services as the provider or entity.

(b) Provider-related donations will be determined to have no direct or indirect relationship to Medicaid payments if those donations are not returned to the individual provider, the provider class, or related entity under a hold harmless provision or practice, as described in paragraph (c) of this section.

(c) A hold harmless practice exists if any of the following applies:

(1) The State (or other unit of government) provides for a direct or indirect non-Medicaid payment to those providers or others making, or responsible for, the donation, and the payment amount is positively correlated to the donation. A positive correlation includes any positive relationship between these variables, even if not consistent over time.

(2) All or any portion of the Medicaid payment to the donor, provider class, or related entity, varies based only on the amount of the donation, including where Medicaid payment is conditional on receipt of the donation.

(3) The State (or other unit of government) receiving the donation provides for any direct or indirect payment, offset, or waiver such that the provision of that payment, offset, or waiver directly or indirectly guarantees to return any portion of the donation to the provider (or other parties responsible for the donation).

(d) CMS will presume provider-related donations to be bona fide if the voluntary payments, including, but not limited to, gifts, contributions, presentations or awards, made by or on behalf of individual health care providers to the State, county, or any other unit of local government does not exceed—

(1) $5,000 per year in the case of an individual provider donation; or

(2) $50,000 per year in the case of a donation from any health care organizational entity.

(e) To the extent that a donation presumed to be bona fide contains a hold harmless provision, as described in paragraph (c) of this section, it will not be considered a bona fide donation. When provider-related donations are not bona fide, CMS will deduct this amount from the State's medical assistance expenditures before calculating FFP. This offset will apply to all years the State received such donations and any subsequent fiscal year in which a similar donation is received.

[57 FR 55138, Nov. 24, 1992, as amended at 73 FR 9698, Feb. 22, 2008]

§ 433.55 Health care-related taxes defined.

(a) A health care-related tax is a licensing fee, assessment, or other mandatory payment that is related to—

(1) Health care items or services;

(2) The provision of, or the authority to provide, the health care items or services; or

(3) The payment for the health care items or services.

(b) A tax will be considered to be related to health care items or services under paragraph (a)(1) of this section if at least 85 percent of the burden of the tax revenue falls on health care providers.

(c) A tax is considered to be health care related if the tax is not limited to health care items or services, but the treatment of individuals or entities providing or paying for those health care items or services is different than the tax treatment provided to other individuals or entities.

(d) A health care-related tax does not include payment of a criminal or civil fine or penalty, unless the fine or penalty was imposed instead of a tax.

(e) Health care insurance premiums and health maintenance organization premiums paid by an individual or group to ensure coverage or enrollment are not considered to be payments for health care items and services for purposes of determining whether a health care-related tax exists.

§ 433.56 Classes of health care services and providers defined.

(a) For purposes of this subpart, each of the following will be considered as a separate class of health care items or services:

(1) Inpatient hospital services;

(2) Outpatient hospital services;

(3) Nursing facility services (other than services of intermediate care facilities for the mentally retarded);

(4) Intermediate care facility services for the mentally retarded, and similar services furnished by community-based residences for the mentally retarded, under a waiver under section 1915(c) of the Act, in a State in which, as of December 24, 1992, at least 85 percent of such facilities were classified as ICF/MRs prior to the grant of the waiver;

(5) Physician services;

(6) Home health care services;

(7) Outpatient prescription drugs;

(8) Services of managed care organizations (including health maintenance organizations, preferred provider organizations);

(9) Ambulatory surgical center services, as described for purposes of the Medicare program in section 1832(a)(2)(F)(i) of the Social Security Act. These services are defined to include facility services only and do not include surgical procedures;

(10) Dental services;

(11) Podiatric services;

(12) Chiropractic services;

(13) Optometric/optician services;

(14) Psychological services;

(15) Therapist services, defined to include physical therapy, speech therapy, occupational therapy, respiratory therapy, audiological services, and rehabilitative specialist services;

(16) Nursing services, defined to include all nursing services, including services of nurse midwives, nurse practitioners, and private duty nurses;

(17) Laboratory and x-ray services, defined as services provided in a licensed, free-standing laboratory or x-ray facility. This definition does not include laboratory or x-ray services provided in a physician's office, hospital inpatient department, or hospital outpatient department;

(18) Emergency ambulance services; and

(19) Other health care items or services not listed above on which the State has enacted a licensing or certification fee, subject to the following:

(i) The fee must be broad based and uniform or the State must receive a waiver of these requirements;

(ii) The payer of the fee cannot be held harmless; and

(iii) The aggregate amount of the fee cannot exceed the State's estimated cost of operating the licensing or certification program.

(b) Taxes that pertain to each class must apply to all items and services within the class, regardless of whether the items and services are furnished by or through a Medicaid-certified or licensed provider.

[57 FR 55138, Nov. 24, 1992, as amended at 58 FR 43180, Aug. 13, 1993; 73 FR 9698, Feb. 22, 2008]